

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> HCP <input type="checkbox"/> IE <input type="checkbox"/> IC	Response Timely Filed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Requestor's Name and Address Osteopathic Medical Center of Texas 1000 Montgomery St. Ft. Worth, TX 76107 76107	MDR Tracking No.: M4-04-0410-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address West Texas Educational Insurance c/o Cunningham Lindsey US Inc. Bpx 11	Date of Injury:
	Employer's Name: Granbury ISD
	Insurance Carrier's No.: WTED010659

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/29/03	02/03/03	Inpatient Hospitalization	\$25,401.43	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

A Position Summary was not submitted; however, the Requestor's rationale on the Table of Disputed Services states, "Sop loss rule under facility, insurance company is doing unnecessary audits. Rule states personal items or undocumented items are all that can be audited off the bill."

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary states in part, "...Forte pre-authorized a four-day inpatient stay as medically necessary. Hospital charges for the first four days were reduced to usual and customary based on the geographical area. After reduction, the hospital charges were below \$40,000 making the bill payable at the per diem rate. Payment was made at the surgical per diem rate for four days, along with the implant charges paid at cost plus 10%..."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 5 days, however, the Respondents preauthorization company authorized 4 days (consisting of 4 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to \$4,472.00 (4 times \$1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit invoices for the implantables; however, the insurance carrier submitted one invoice as follows:

DePuy Invoice:	\$ 8,275.00 x 10% = \$ 9,102.50
4 day LOS:	\$ 1,118.00 x 4 = <u>4,472.00</u>
Total Reimbursement:	\$13,574.50

The Requestor billed \$51,967.90 and was reimbursed for a total of \$13,574.50. Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

Marguerite Foster

03/22/05

Authorized Signature

Typed Name

Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____